

FFS Provider Orientation Training Acknowledgment

I,	, have received and read a copy of the
(Print name clearly)	,
County of San Bernardino Medi-Cal F	See-For-Service (FFS) Provider Manual and
MHP Provider Training materials. I u	inderstand its contents, and acknowledge my
responsibility to adhere to the policy and practices described therein.	
Provider Signature and License	e Number Date